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A Review of the Health Sector Reform Agenda (HSRA) Implementation Progress

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Acronyms

AO	administrative order
BFAD	Bureau of Food and Drugs
BHDT	Bureau of Health Devices and Technology
BHFS	Bureau of Health Facilities and Services
BHW	*barangay* (village) health worker
BLHD	Bureau of Local Health Development
BnB	*botika ng barangay* (village drugstore)
BPS	Bureau of Product Standards
BQIHS	Bureau of Quarantine and International Health Surveillance
CDD	Control of Diarrheal Diseases Program
cGMP	current good manufacturing practice
CHD	Center for Health Development
CO	central office
CPG	clinical practice guidelines
DAR	Department of Agrarian Reform
DBM	Department of Budget and Management
DOF	Department of Finance
DOH	Department of Health
DOLE	Department of Labor and Employment
DOTS	directly observed treatment, short course
DSWD	Department of Social Welfare and Development
EO	executive order
EPI	Expanded Program on Immunization
GMA	Greater Medicare Access
HB	House Bill
HFDP	Health Finance Development Project
HP	health passport
HPDPB	Health Policy Development and Planning Bureau
HSRA	Health Sector Reform Agenda
ILHZ	Inter-local Health Zone
IPP	Individually-Paying Program
IT	information technology
ITRMC	Ilocos Training and Regional Medical Center
LGU	local government unit
LHAD	Local Health Assistance Division
MEWAP	Malaria Eradication Workers Association of the Philippines
MOA	memorandum of agreement
MSH-HSRTAP	Management Sciences for Health – Health Sector Reform Technical Assistance Project
MSW	medical social worker
NCDPC	National Center for Disease Prevention and Control
NCR	National Capital Region

NDP	National Drug Policy
NGO	non-government organization
NHIP	National Health Insurance Program
NOH	National Objectives for Health
NSVD	normal spontaneous vaginal delivery
NTP	National Tuberculosis Program
OSEC	Office of the Secretary
PCA	Philippine Coconut Authority
PDI	parallel drug importation
PHIC/PhilHealth	Philippine Health Insurance Corporation
PHO	Provincial Health Office
PITC	Philippine International Trading Corporation
PMO	Project Management Office
QA	quality assurance
QMMC	Quirino Memorial Medical Center
RD	regional director
RHU	rural health unit
RITM	Research Institute for Tropical Medicine
RUV	relative unit value
SB	*Sangguniang Bayan* (Municipal Council); Senate Bill
SEMP	Social Expenditure Management Project
SHI	social health insurance
SP	**Sangguniang Panlalawigan *(Provincial Council)***
SV	support value
TA	technical assistance
TB	tuberculosis
TC	therapeutics committee
TCG	technical coordination group
TQM	total quality management
UP-NIH	University of the Philippines – National Institutes of Health
USAID	United States Agency for International Development
USEC	undersecretary
WHO	World Health Organization

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Overview

This report presents the findings of the review of the implementation progress of the Department of Health's (DOH) Health Sector Reform Agenda (HSRA). The review was commissioned specifically to 1) provide an overview of the progress of HSRA implementation, 2) analyze the factors affecting what has been accomplished thus far, and 3) present recommendations for future implementation activities.

The review covered the period dating from 1999 when the HSRA monograph was published up to the last quarter of 2002. The review compared activities undertaken and outcomes realized with the targets defined in the HSRA implementation plan, and the observed variance analyzed. Recommendations for future activities were then derived from the analysis.

Information used in this review came from reports, secondary data, and key informant interviews. The conclusions and recommendations made here are, therefore, based on soft data and include value judgments exercised by the authors.

Three groups of HSRA implementation activities were reviewed: 1) convergence site development, 2) off-site reform activities, and 3) crosscutting reform activities. Convergence site development refers to activities directed at meeting the targeted number of convergence sites as well as initiatives designed to meet targets and desired outcomes in a particular site. Off-site reform activities refer to non-site related work in the five HSRA areas – hospitals, the National Health Insurance Program (NHIP), public health, health regulation, and local health systems development. Crosscutting reform activities refer to reorganization or reengineering; finance and budget reforms; pursuit of the DOH legislative agenda; and overall HSRA implementation management, coordination, and monitoring.

The review found that while target activities and outcomes have largely been unmet, there has been significant progress in convergence site development. Progress in off-site reform areas has slowed down, save for advances made in NHIP. The least progress was found in crosscutting reform activities. It must be pointed out, however, that HSRA implementation, while delayed and pursued at a much slower pace than planned, has gone beyond the critical first steps. What makes this accomplishment remarkable is that this was achieved under adverse conditions – disruptions owing to political change, severe budget cuts, and inadequate management infrastructure.

Its accomplishments notwithstanding, HSRA implementation is not yet out of the woods. While HSRA's accomplishments may not be reversed, its momentum can grind to a halt. Risk factors still have to be addressed and adjustments in the HSRA implementation strategy have to be made. Implementation of the reforms as a single package with all components advancing synchronously will require an implementation management, coordination, and

monitoring unit at both central and regional levels backed up by a clear mandate, budget, and political capital. Lessons learned from the first batch of convergence sites must be drawn up and shared with other localities to allow local champions of convergence site development to effectively influence the national arena.

Section 1

The Health Sector Reform Agenda and Its Implementation Strategy

In 1999, DOH published a comprehensive plan for changing the Philippine health care system. The monograph *Health Sector Reform Agenda Philippines, 1999 – 2004* argues that radical reform is necessary to substantially improve the performance of the health care system.

The diagnosis presented by HSRA is not new. The conclusion that the health status of Filipinos, characterized by a low population average with a high variance due largely to inequities in access to and inefficiencies in allocation of health care resources, was put on the table way back in the early 1990s by DOH initiatives like the Philippine Health Development Project and Health Finance Development Project (HFDP). The analyses made by DOH at that time already provided much of the reform recommendations contained in HSRA.

In a way, HSRA is old wine in a new bottle. But what may be considered intoxicating about it is not the spirit of its contents but that sector-wide reforms are presented as a single package. Reforms in social health insurance, public hospitals, local health systems, health regulation, and public health are recognized as highly interdependent. Hence, the HSRA implementation plan specified reform activities, and set its timing and resource requirements determined as single blister pack that guides what is to be undertaken, in what dosage, and when.

Considering its demarcation in the timeline of Philippine health sector development, HSRA could not have been drawn up without the accomplishments in earlier periods. Up until the mid-1980s, the public health care delivery system, from the *barangay* (village) health station all the way up to regional and national medical centers, was built and used as the primary policy instrument to influence the health status of Filipinos. But the marginal product of direct service delivery funded by public subsidies had to decline with increasing application. Other policy instruments to influence health outcomes had to be developed and employed in tandem so that between 1986 and 1996 "enabling acts" for health care reform were instituted. Executive Order (EO) No. 119 provided the basis for the DOH reorganization. The Generics Drug Act pushed health regulation out of the standards and licensing mold into competition promotion. The Local Government Code broadened the scope of governance for health. The National Health Insurance Act, on the other hand, magnified the powers for using social insurance not only to reduce the financial burden that health care imposes on families, but also for leveraging for competitively priced and effective health services, including those delivered by private health care providers.

In this light, HSRA could be read as a plan to exercise in a coherent and well-orchestrated fashion the policy instruments of financing, regulation, information, and direct service delivery as mandated by the health reforms enabling laws:

- Public hospitals had to become effective instruments not only in inpatient care delivery, but also in ensuring that subsidies are equitably dispensed through socialized fees. Moreover, public hospitals had to be competitive and, therefore, influence services and prices in the private sector.

- Technical leadership in public health programs – information, research, and technical guidelines – had to become an effective instrument in influencing the effectiveness of service delivery in the field that was devolved, and shared with private providers. In addition, the plan proposed a financial instrument in the form of multi-year budgets to ensure that priority public health campaigns are sustained long enough to meet target impacts.

- Local health systems, where local government units jointly govern and share responsibilities for a health catchment area, were recognized as the frontline in service delivery and sustained financing.

- The capacities of health regulatory agencies had to be upgraded to effectively perform traditional functions as well as new roles in public information and competition promotion.

- By expanding enrollment and improving benefits, NHIP would not only reduce financing burden but also assume a better position to leverage for effective and affordable services from both public and private providers.

HSRA argues that the exercise of the above reform instruments or areas "are highly interdependent, complementary, and, therefore, expected to be implemented as a package." The interrelationship described is simple: "health financing reforms through NHIP expansion will make hospital autonomy viable and will ensure that the poor remain protected. Hospital reforms, in turn, will free up resources for investment in public health programs, health systems development, and health regulation at national and local levels. Effective public health programs and local health systems should relieve NHIP from paying for hospitalizations that should have otherwise been prevented or better handled at primary care facilities." One might add that effective regulation would help ensure that health facilities, equipment, and products met quality standards and are competitively priced so that national and local health budgets and NHIP benefits get better value for money.

The requirements enumerated by DOH for successful HSRA implementation have led many to consider the plan too ambitious. New investments, estimated at PhP 112 billion, needed to be infused over a five-year period to upgrade facilities, strengthen capacities, pay for premium subsidies, and ensure adequate supply of drugs and medicines. DOH and its attached agencies had to undergo a comprehensive reorganization or reengineering program. Additional legislation and executive orders had to be enacted to address gaps not covered by the enabling acts. Moreover, a new culture – a health reform culture like the one instilled in Mexico and Chile – needed to be implanted in the health bureaucracy.

The first steps towards implementation were taken in 1999 well before the HSRA monograph was published. The Philippine Health Insurance Corporation (PHIC) started an aggressive social marketing campaign to expand enrollment. Reimbursement ceilings were adjusted to raise the value of insurance benefits. Once institutional barriers were removed, the first batch of orders under the parallel importation program was placed. The reengineering of DOH central offices went underway. Drug procurement reforms were initiated at the central level so that procurement prices of TB drugs dropped by as much as 40 per cent.

By mid-2000 DOH recognized that severe budget constraints and expectations of disruptions from impending political change made it unlikely that HSRA can be fully implemented at a national scale within the period expected. It was then proposed that the reform package be implemented in selected implementation sites or convergence sites. The idea was to generate sufficient improvements in health care delivery and financing in provinces and cities to a point where the areas' residents perceive tangible benefits from the reforms. Satisfied residents and their political representatives would then form a strong constituency behind the reform package, which in turn would create "irreversible momentum" for HSRA implementation.

The revised HSRA implementation strategy contained four critical elements:

- **Health Passport (HP) as concrete entitlement to health services accorded to targeted beneficiaries.** HP essentially lists a comprehensive package of public and personal health care benefits delivered by DOH, PHIC, and the local government unit (LGU) where the beneficiaries reside. HP identifies for the holder the accredited providers of the service package, assuring beneficiaries of affordable and quality care. HP also spells out responsibilities of the holder, DOH, PHIC, and LGU.

- **Convergence site development**. While the product of convergence is supposed to be manifested in HP, its distribution on a nationwide scale was considered not feasible and strategically inferior to focusing product development and distribution in selected implementation sites. Given the limited time, people and funds, DOH estimated that as much as 30 per cent coverage for HP could be achieved nationwide. On the other hand, universal HP coverage could be attained in 30 per cent of localities, creating a springboard for "irreversible momentum" for HSRA implementation. The implementation strategy required that site selection be based on favorable local conditions, strong political interest, and support of local executives so that potential neighborhood effects are realized.

- **Non-site or off-site implementation activities in the five HSRA areas were to be prioritized to those that were critical for convergence site development.** Drugs and medicines purchased from the parallel importation strategy must be directed to convergence sites. DOH hospitals that

serve as highest referral level must be given priority for hospital reform activities.

- **Private sector partnership was recognized as critical to successful implementation.** By contracting private providers, HSRA can be implemented without having to build a large DOH or PHIC bureaucracy. Private laboratories can be contracted to perform Bureau of Food and Drugs (BFAD) testing functions. Subcontractors can be tapped to help PHIC enroll and manage membership as well as pay out benefits.

The strategy described here was adopted by DOH and issued as Administrative Order (AO) No. 37 s. 2001, "**Guidelines for the Operationalization of the Health Sector Reform Implementation Plan by all Bureaus, Programs, Offices, Centers for Health Development, and Attached Agencies of the Department of Health**." The administrative order contained a description of the strategy, outlined its critical activities and target outcomes for the period 2001 to 2004, and mandated the creation of implementation management and coordination units at the central, regional, and convergence site levels.

This review employed AO No. 37 as the benchmark for measuring the progress of HSRA implementation.

Section 2

Progress in Convergence Site Development

The implementation plan targeted 65 convergence sites to be developed between 2001 and 2004. The number of sites was arrived at through consultations with DOH and PHIC regional staff. Sixty-five provinces and cities were considered ripe for convergence site development.

Local executives in the proposed sites were recognized as dynamic and reform-oriented. Elements of the convergence strategy like enrollment of indigent members in PHIC or innovations in hospital management and financing were taking root and there were indications that LGUs in the sites were interested in forming cooperative arrangements to improve shared health facilities. Although no formal analysis was conducted, presumably 65 sites were considered more than sufficient to create rippling effects throughout the country.

Of the 30 areas targeted for convergence site development in 2001, activities were initiated in only 13 – eight primary and five expansion – sites (see Table 1). The eight were considered advanced implementation sites (see Box 1 for primary convergence sites) on which assistance from DOH as well as Management Sciences for Health – Health Sector Reform Technical Assistance Project (MSH–HSRTAP) was focused. In 2000, convergence site development activities were initiated in 15 expansion convergence sites.

Table 1. Number of convergence sites, by targets and accomplishments, 2001-2004

	2001	2002	2003	2004	TOTAL
Target	30	+24	+5	+6	65
Accomplishment	13	+17			

Box 1. Primary and expansion convergence sites

PRIMARY CONVERGENCE SITES	EXPANSION CONVERGENCE SITES	
1. Capiz	1. South Leyte	9. Laguna
2. Pangasinan	2. Palawan	10. Quezon
3. Bulacan	3. Ifugao	11. Biliran
4. Negros Oriental	4. Baguio City	12. North Cotabato
5. Misamis Occidental	5. Agusan del Sur	13. Zamboanga del Sur
6. Nueva Vizcaya	6. Ilocos Norte	14. Surigao del Sur
7. Pasay City	7. Cagayan	15. Davao del Norte
8. South Cotabato	8. Nueva Ecija	
	ADDITIONAL SITES	
	1. Oriental Mindoro	5. Siquijor
	2. Romblon	6. Zamboanga
	3. Catanduanes	7. Sibugay
	4. Iloilo City	8. Bukidnon

Less than half the target sites for 2001 and 2002 were met by DOH. This shortfall could be attributed to a number of factors including delays owing to change in government, limited resources allocated for site development activities, and the absence of convergence site development units – especially at the regional level – with the mandate and capability to facilitate activities at the field level. In addition, the

level of effort required to effectively carry out convergence site development activities might have been underestimated.

Target activities and outcomes described in Table 2 were not completely met even in the eight advanced implementation sites. Nonetheless, considerable progress has been made in these sites. An assessment conducted by the University of the Philippines National Institutes of Health (UP-NIH) – Institute of Clinical Epidemiology suggests that success factors in these sites include reform-minded local executives; elements of convergence that were already in place or ongoing; collaborative effort between DOH, PHIC, and LGU staff; and the presence of technical assistance (TA) provided by MSH-HSRTAP.

Table 2 lists six critical elements for the convergence strategy: 1) solid institutional foundation, 2) high level of enrollment of beneficiaries, 3) entitlement to a fully integrated package of benefits, 4) access to quality service providers, 5) access to quality and affordable medicines and medical equipment, and 6) sustained financing. The degree of success in meeting the activities and target outcomes for each of these elements varied from one site to another.

In most sites, a memorandum of agreement (MOA) among participating LGUs, DOH, and PHIC was the common instrument for building the institutional foundation for the Inter-local Health Zone (ILHZ). The UP-NIH assessment, however, observed that strong leadership at the provincial level might be the more critical ingredient. But in most cases, the willingness to proceed with convergence site development was signaled by participation in a convergence site planning workshop where the specific site design, activities and outcomes, and the shared responsibilities of participants were articulated.

Enrollment focused on the Indigent Program (IP) of PHIC. None of the sites reached the enrollment target of 85 per cent of the population. The gap remained among the self-employed residents in the convergence sites. There was no documentation of efforts or mechanisms for enrolling the self-employed in convergence sites.

The Health Passport was abandoned and in some sites replaced by PhilHealth Plus, a benefit package that includes specific outpatient services delivered by accredited rural health units (RHUs). The political demise of the Health Passport severed the link between priority public health services of national programs with the convergence site. In most sites, integrated health benefits only covered hospital and RHU services provided by the PHIC Indigent Program.

Efforts to ensure access to quality service providers were mostly focused on improving services delivered by provincial and some district hospitals. Progress in financial management, revenue generation, and drug procurement is exemplary. Improved drug management and pooled procurement alone have significantly reduced prices of essential drugs. In the case of Pangasinan, improved drug management systems reduced various drug prices by an average of 45 per cent between 2000 – 2001 and between 2001 – 2002. In Capiz, the presence of drugs from the parallel importation program further reduced prices by 50 per cent and significantly increased patients' access to medicines.

Table 2. Desired outcomes and critical activities, by specific concern , in convergence sites		
CONCERN	**DESIRED OUTCOMES**	**CRITICAL ACTIVITIES**
Institutional foundation	Long-term contract among DOH, PHIC, LGUs	• Development of appropriate contractual instruments • Orientation on implementation strategy • Development of reform package and operational plan
Targeting and enrollment of beneficiaries	85% of residents enrolled	• Social marketing • Development of enrollment mechanisms • Management of enrollment and membership
Entitlement to integrated benefits	Full coverage of public health services and personal care under HP	• Development of new benefit packages • Information campaign on benefits and entitlement • Coordination of DOH, LGU, and PHIC services
Access to quality providers	Sufficient accredited providers in the area who fully comply with clinical practice guidelines (CPGs) and networking guidelines	• Development of CPGs especially for HP-covered services • Upgrading of facilities based on CPG compliance requirements • Building of referral network • Introduction of performance-based budgeting for DOH and LGU facilities
Access to quality and affordable medicines and equipment	• Only Bureau of Health Devices and Technology (BHDT)-qualified medical equipment and BFAD qualified drug retailers operating in the site • Outlets for reasonably processed and quality drugs available in the site	• Assessment of facilities, equipment, and retailers by BHDT, BFAD, and Bureau of Health Facilities and Services (BHFS) • Issuance of quality seal by BFAD and BHDT • Implementation of efficient drug management and procurement systems • Distribution of reasonably processed and quality drugs in selected outlets
Sustained financing	• LGU remittance of premium subsidies at least 90% • Cost sharing among LGUs sustained • Value for money in PHIC benefit spending is secured through effective provider payment schemes • PHIC progressively assumes the financing of public health services	• Strengthening of premium collection systems • Introduction of alternative provider payment schemes

These advances notwithstanding, questions regarding the sustainability of the program are being raised in various convergence sites. Procurement delays at the central level plus the limited amounts being procured have led to drug shortages. The average inventory at the provincial level is 30 days worth of drugs and medicines, but the Philippine International Trading Corporation (PITC) takes at least four months to deliver orders. With this inventory problem, what private retailers would do to ease competitive pressures from parallel imported drugs is to stop selling the same medicines when parallel drug importation (PDI) drugs are available and then reintroduce stocks when PDI drugs run out. A sufficient and steady supply of parallel imported drugs needs to be secured to maintain competitive pressure on the market.

Activities to ensure presence of accredited drug retailers, and medical equipment through so-called BFAD and BHDT quality seals have been notably absent at convergence sites. This is one component of the reform where true convergence was not quite successful.

Sustained financing for the convergence sites is mainly focused on cost sharing of premium subsidy counterpart payments by LGUs. In some cases, cost sharing, particularly of the cost of operating district hospitals, includes contributions in kind (e.g., drugs and medicines, supplies, personnel, ambulance or vehicles). According to LGUs, the Department of Budget and Management (DBM) and the Commission on Audit disallow money contributions. Hence, the actual budget allocations remain with the LGU for liquidation to buy medicines and supplies or even hire contractual personnel needed by shared hospital facilities.

Formal convergence site development activities in the advanced or primary convergence sites listed in Box 1 only had a little over a year of work. Although reforms in these sites started much earlier, it would take a while before full convergence is completed.

A real concern was raised with regard to expansion sites – documentation of activities in expansion sites is poor. This suggests that the level of effort exerted in expansion sites is nowhere near that spent on the eight primary sites. This points to the lack of resources (people, skills, budget, and organization) at the central and regional levels to facilitate site development activities. Note that a critical outcome of convergence is the creation of neighborhood effects across LGUs. In a way, that convergence activities have started at all in the expansion sights is evidence of the momentum generation potentials of convergence site development. If DOH fails to sustain reforms in the expansion sites, it stands to lose on the irreversibility aspect of the HSRA implementation strategy. DOH must resist tendencies to initiate convergence site development and conduct convergence workshops and count these as target accomplishments. There is a potential backlash here—given the heightened expectations of participating LGUs, lack of follow-through by DOH and PHIC might cripple convergence development. One can argue that *fewer* sites that are fully developed and where outcomes are felt by beneficiaries will generate more impact than taking the first steps sans follow-through in *many* sites.

The progress made in the eight primary convergence sites is relatively well-documented. A summary of the progress in each site based on DOH and MSH-HSRTAP documents is presented in Annex Tables 1 to 8.

An interesting concept promoted by MSH-HSRTAP and reflected in the UP-NIH assessment of the primary convergence sites is that of **best practice**. The idea is to document the technology behind the most successful reform activity in the convergence sites. The danger here though is to interpret best practice as a component of convergence that works, implying that others do not. This interpretation is easily avoided by extending the idea behind best practice and developing a convergence prototype, not from theoretical constructs, but from best practice. It might be more convenient to communicate the lessons from the eight convergence sites to other interested LGUs using a best practice technology menu an example of which is shown in Table 3.

The best practice menu in Table 3 points out weaknesses of convergence site as practiced relative to targets envisioned in the implementation plan. All sites have shortcomings with respect to enrollment expansion for individually paying members (i.e., self-employed); securing the link between centrally and locally provided public health programs like TB; and presence of health regulations in equipment, drug retailing, and outpatient clinic facilities. These shortcomings represent the remaining gaps in realizing complete convergence.

Questions have been raised whether the emergence of best practices induces true convergence. Full convergence of the five HSRA areas have yet to be achieved. But the introduction of reform elements has led LGUs to direct development efforts towards convergence. Take for example reforms that have led to increased enrollment of indigent members. Population coverage targets have led LGUs to devise and enforce premium subsidy sharing arrangements. Once enrollment rates are up, local executives begin to face the question of access to accredited providers and increased benefit utilization by members. This has led LGUs in convergence sites to undertake critical upgrading of local health facilities including rural health units (RHUs). Value for money considerations has then led to innovations like pooled procurement and participation in the PDI program.

In sites like Negros Oriental there is recognition that greater improvement in the delivery system cannot be supported unless insurance enrollment goes beyond indigent members and covers the self-employed sections of the population. What seems to be generating the drive towards full convergence in the selected sites is that local systems are complete and small enough so that the need for a full package of reforms is readily felt.

Table 3. Best practices in convergence site development	
STRATEGIC COMPONENT	**BEST PRACTICE/S**
Institutional foundation for ILHZ	ILHZs organized through a resolution of the provincial health board and backed up by SP and SB sanctions. Supporting each ILHZ is a MOA, entered into by participating municipalities, that spells out responsibilities and resource sharing (Negros Oriental)
Targeting and enrollment of beneficiaries	• PHIC/DSWD/LGU joint social marketing for indigent enrollment (all primary sites)
Entitlement to integrated benefits	• Integration of public health services through efficient and functional local health system geared towards sustained delivery of own public health programs including those traditionally delivered by national vertical programs such as the National Tuberculosis Program (NTP), Control of Diarrheal Diseases Program (CDD), and Expanded Program on Immunization (EPI). These programs were spelled out as benefit entitlement of Health Passport holders (Pasay City) • RHU accredited to deliver PHIC outpatient benefit packages (all primary convergence sites) • HP replaced by PhilHealth Plus (Pasay City)
Access to quality providers	• The public health delivery system is divided into health zones each with *Sentrong Sigla*- and PHIC-accredited health centers that lead a network of well-trained *barangay* health workers (BHWs). Functional referral system operates from the level of the BHW to the health center to the Pasay City General Hospital (Pasay City) • Hospital staff trained on financial management and operation of efficient socialized billing and collection systems. Cost studies form part of fee-setting policy formulation. Quality assurance (QA) committees and therapeutics committees (TCs) organized and operating in all hospitals. Hospital revenues utilized for upgrading, purchase of drugs, staff incentives, and partly shared with other facilities (Pangasinan) • Broad-based representation in hospital boards created to manage hospitals (Negros Oriental) • Fiscal autonomy in the provincial hospital where up to 90% of revenues are retained by the facility (Capiz and Negros Oriental) • Upgrading of hospital facilities integral to revenue enhancement (Pangasinan and Negros Oriental) • Networking between public and private hospital facilities (Pangasinan and Capiz)
Access to quality and affordable medicines and equipment	• Pooled procurement of drugs for all provincial hospitals (Pangasinan, Nueva Vizcaya, Bulacan, Negros Oriental, and Capiz) • Actively functioning therapeutics committee (Pangasinan, Capiz, Bulacan) • Distribution of PDI medicines, albeit delayed owing to PITC (Pangasinan, Bulacan, Negros Oriental, Misamis Occidental, South Cotabato, and Capiz)
Sustained financing	• Participating LGUs contribute portions of their respective economic development fund to a common health fund managed by an ILHZ technical management committee (Negros Oriental) • Indigent members make a contribution for insurance premium to deter dole-out dependence (Negros Oriental) • Medical staff time shared among LGUs in ILHZ (Capiz) Private corporations tapped to help finance the premium contribution of indigent members (Pasay City)

Section 3

Progress in Off-site Reforms

This section presents the progress of off-site reform activities in four HSRA areas – hospitals, public health programs, health regulation, and the National Health Insurance Program.

1. DOH Hospitals

The HSRA implementation plan recognizes that, at the beginning, DOH hospitals are likely to serve catchment areas outside the targeted convergence sites. Thus reform activities need to be pursued independently. According to the implementation plan, the strategy for hospital reforms is to change governance and incentive structures within hospital facilities that would enhance the competitiveness of DOH hospitals in terms of quality and cost of hospital care. The approach is to transform DOH hospitals into government-owned and operated corporations that are fiscally and administratively autonomous. This means that hospital authorities are able to chart the hospitals' development and make decisions to realize this. In addition, hospitals should be able to introduce socialized pricing schemes that would enhance cost recovery while maintaining their equity objectives. Revenue enhancement, however, should be complemented by the ability of hospital facilities to retain revenues and spend these according to the hospital's priorities.

Given that public hospitals have had very little opportunity to undertake capital investments in the last 10 years, a requirement for hospital reform is for critical upgrading to be pursued so that these facilities are able to compete in the open market for hospital care. The implementation plan suggests that in order to determine the reasonable amount of investment, upgrading must be based on predetermined service delivery standards. A specific instrument is to require facilities to follow clinical practice guidelines (CPGs) and introduce only those investments needed by the facility for compliance.

The implementation plan recognizes that hospitals identified to be transformed into government-owned and controlled corporations would still require direct government subsidies as a leverage for it to meet social objectives. An operational mechanism suggested in the implementation plan is performance-based budgeting that would allow direct public subsidies to autonomous public hospitals to increase when –

- private providers are absent in the catchment area,
- access to quality care by the poor have yet to be supported by NHIP,
- facilities perform socially beneficial activities such as research and training that directly benefit other public and private facilities serving the catchment area, and
- the presence of the public facility puts competitive pressure on the price and quality of care delivered by private providers in the catchment area.

Several studies were completed in 2001 to examine the conditions, quality, and resource requirements of DOH hospital facilities targeted for reforms (see studies commissioned by MSH and WHO). These studies provided the technical basis for selecting 15 facilities given priority for hospital reforms in 2002 to 2004. Of this target, five hospitals were selected to be transformed into government-owned and controlled corporations by the end of 2002 (see Table 4).

Table 4. Accomplishments in DOH hospital reforms

TARGET	ACCOMPLISHMENT
• Baseline studies for target hospitals completed by 2001	Completed
• Legal basis for hospital corporatization established by 2001	Executive order for QMMC and ITRMC submitted for Pres. Macapagal-Arroyo's approval
• First batch of five hospitals corporatized by 2002	QMMC and ITRMC chosen as pilot hospitals awaiting Pres. Macapagal-Arroyo's approval
• Clinical practice guidelines for hospital services developed by 2001	Still to be developed jointly by DOH and PHIC
• Hospitals upgraded for CPG compliance by 2002	Actual upgrading of selected facilities not linked to CPG compliance
• Guidelines for socialized cost recovery schemes in corporatized facilities introduced by 2002	• Fee setting policy and revenue retention limited by DOH/DBM guidelines (revenue retention ceiling was raised from PhP 600 million to PhP 1 billion for 2003) • Medical social worker's patient classification system revised
• Performance-based budgets for DOH hospitals introduced by 2002	Hospital budgets still input- rather than output-based

As of September 2002, the target number of hospitals up for corporatization was reduced to two facilities – Quirino Memorial Medical Center (QMMC) and Ilocos Training and Regional Medical Center (ITRMC). The legal basis for the corporatization of these facilities was developed in the form of an executive order to be signed by the President of the Philippines. The draft EOs for QMMC and ITRMC were submitted in July 2002 to the Office of the President for signing. The drafts have been reviewed by the Legal Division of the Office of the President as well as the Presidential Committee on Good Governance, and were endorsed to DBM. The status of these enabling instruments or when this will be signed, however, is not known.

Clinical practice guidelines to be used to track improvements in quality of care, and on which critical upgrading was supposed to be based have yet to be enforced by DOH and PHIC. Nonetheless, critical upgrading has proceeded. In targeted hospital facilities, hospital directors and staff have undergone training in hospital management including finance, revenue enhancement, cost containment, and socialized fee setting. This has raised the confidence of hospital staff to implement cost recovery measures within their respective facilities.

The capacity to raise and utilize revenue helped DOH hospital facilities cope with recent budget cuts (a feature that is not open to public health programs). Although the timing of releases and revenue utilization ceilings imposed by DBM remain restrictive, hospitals are able to provide for staff incentives and critical medical supplies, albeit on a limited scale. QMMC points out that this reason alone has made corporatization attractive despite the opposition in other facilities.

Draft transition plans have been prepared for the two remaining targets for hospital corporatization, and a business plan was drawn up for ITRMC. To ensure a smooth transition, the business plan needs to be strengthened to include the facility's governance structure, present its socialized fee-setting policy, make revenue forecasts, and estimate operating and capital expenditures as well as requirements for direct public subsidy for the first five years of operation.

The HSRA monograph describes how hospital upgrading was prioritized among the various hospital facilities across the various regions in the country. The upgrading plan presents the number of facilities up for capacity building as well as a queuing sequence. The HSRA clearly placed greater priority on hospitals in Mindanao for upgrading – they are first in line and greater in number. Metro Manila hospitals were given the lowest priority.

Table 5 shows that only 10 hospitals in Mindanao have received critical upgrading when 79 were targeted for 2000 – 2001. Mindanao received less than 15 per cent of expected upgrading. Hospitals in the Visayas had a higher rate of 27 per cent. Hospitals in Luzon had an upgrading rate close to 20 per cent in spite of the area being slated for upgrading in 2002 – 2003 yet. Metro Manila has an upgrading rate equal to that of Mindanao in spite of the upgrading being targeted for 2003 – 2004 yet.

Table 5. Target and actual number of public health facilities for critical upgrading

FACILITY	MINDANAO (2000-01)		VISAYAS (2001-02)		LUZON (2002-03)		NCR (2003-04)	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual
Core district hospitals	48	1	32	4	76	7	1	0
City hospitals							12	1
Provincial hospitals	24	5	15	9	36	14		
Medical centers	4	3	3	1	3	0		
Regional hospitals	3	1	2	1	4	2		
Specialty hospitals			1	0			1	1
Research hospitals			1	0				
TOTAL	79	10	54	15	119	23	14	2

Eight DOH facilities were included among those receiving funds for upgrading. Except perhaps for QMMC and ITRMC, it is doubtful whether the upgrading received had to do with corporatization, the introduction of CPGs, or because they are the top referral hospitals for a convergence site.

The attention given by HSRA on hospital reforms has a lot to do with its (hospital reforms') relative share in the DOH budget. The concern is that in terms of budget allocation, DOH contradicts its own statements about giving higher priority to public health programs. At the macro level, HSRA aimed at keeping hospital shares fixed (if not reduced) so that more funds can be allocated for public health.

Table 6a. DOH budget allocation by type of service (in billion pesos), 1999-2003

SERVICE	1999	2000	2001	2002	2003
Administration	1.7	1.7	1.7	1.9	1.6
Public health services	2.5	2.2	1.8	1.8	1.4
Hospital services	6.8	6.8	5.9	7.7	7.8
TOTAL	11.2	10.7	9.4	11.4	10.8

Table 6a shows the DOH budget allocation by type of service. The budget for administrative and regulatory functions has remained relatively constant from 1999 to 2003 despite increased activities owing to HSRA implementation. Allocation for public health services, however, has declined from a high of PhP 2.5 billion in 1999 to PhP 1.8 billion in 2002. This allocation is expected to further decrease to PhP 1.4 billion in 2003.

The budget for hospitals, on the other hand, has increased from PhP 6.8 billion in 1999 to PhP 7.7 billion in 2002. Moreover, the share of hospital spending in the DOH budget is expected to reach 72 per cent in 2003 from a low of 61 per cent in 1999 (see Table 6b). There could be three explanations for the rising share of hospital spending in the DOH budget. One, the number of hospitals under DOH management has increased owing to creeping legislated re-nationalization. Two, critical upgrading might have proceeded according to HSRA hospital reform targets. Three, opportunistic Congressional lobbies for selected hospitals increased with the political change in 2001. The bulk of re-nationalized hospitals was brought under DOH management prior to 1999. Only eight facilities have received upgrading. For 2003, the increased ceiling for hospital income retention of about PhP 400 million was taken out of the public health programs budget.

Table 6b. DOH budget share (in per cent), by type of service, 1999-2003

SERVICE	1999 (%)	2000 (%)	2001 (%)	2002 (%)	2003 (%)
Administration	17	16	18	10	15
Public health services	22	20	19	31	13
Hospital services	61	64	63	59	72
TOTAL	100	100	100	100	100

2. Public Health Programs

Two critical strategy elements are presented in HSRA so that public health targets specified in the National Objectives for Health (NOH) can be achieved: 1) effective technical leadership of DOH over local health systems, and 2) sustained performance-based financing

for priority public health programs. Technical leadership is needed to influence performance at the local level in the delivery of priority public health programs. The implementation strategy proposes that in building the capacity for technical leadership the following critical activities need to be undertaken:

- Establishment of national reference facilities
- Upgrading of technical skills at the National Center for Disease Prevention and Control (NCDPC)
- Development of CPGs or technical operations guidelines for public health services
- Regular monitoring of compliance with CPGs and technical guidelines by public and private health care providers
- Strengthening of disease surveillance systems in partnership with local health systems and private providers

RITM (Research Institute for Tropical Medicine) and San Lazaro hospitals have been identified as national reference centers for infectious diseases. However, there is no available information on whether these facilities are being used effectively for this purpose.

There have been training courses, seminars, and conferences organized to upgrade the technical skills of NCDPC. What is alarming is the failure of NCDPC to retain staff knowledgeable of their new roles and functions in the reengineered DOH, and of the strategies outlined in HSRA.

Technical operation manuals have been revised or modified for local application and have been issued by DOH. However, compliance to these guidelines has not been monitored. An interesting example is the claim that up to 90 per cent of RHUs are ready to implement TB DOTS (tuberculosis directly observed treatment, short course) based on training conducted. But actual application of TB DOTS has not been monitored. Moreover, there is no information about the proportion of RHUs that are capable – with the drugs, laboratories, and personnel – to conduct TB DOTS.

Monitoring of the progress of public health programs has been linked to *Sentrong Sigla* (Centers of Vitality) and *Garantisadong Pambata* (Well Child) programs. Since not all facilities are accredited under these programs, DOH is only able to generate information where progress is, by definition, good. Efforts and incentives to upgrade facilities to meet *Sentrong Sigla* standards must be sustained so that all facilities qualify. Until such time, program monitoring will miss out in areas where health facilities do not meet program standards.

Delays in reporting and data processing continue to persist indicating that disease surveillance systems have yet to be strengthened. While it is true that baseline data have been established and targets set for 2004 under the DOH NOH, a comprehensive database that would allow DOH to track the progress or accomplishments of priority health programs with respect to NOH targets has not been put in place.

The gaps in the data shown in Table 7 reflect the level of difficulty and the effort required to monitor progress in disease control activities. In several regions, information on the number of cases screened for TB is not available mainly because data at the provincial level are incomplete and hence, regional level figures cannot be computed. Nonetheless, the number of cases screened is shown here as a measure of the basic effort (that is, case detection) in controlling TB. It would have been interesting to show cure rates or completion rates but the time series data cannot be compared because of the introduction of TB DOTS around 1998. Figures for completion rates and cure rates were much lower after TB DOTS was introduced owing to more stringent measures or standards. For regions where data are complete, a slightly increasing trend (if not flat) is observed. The trajectory observed, however, is not set high enough to meet 2004 targets set for TB control in NOH.

Table 7. Number of cases screened for TB, by region, 1996-2001

REGION	1996	1997	1998	1999	2000	2001
National Capital Region	19,992	21,871	24,488	31,272	34,961	27,039
Cagayan Valley	*na**	*na*	*na*	*na*	9,445	9,173
Cordillera Autonomous Region	1,277	1,300	1,324	1,373	1,404	1,435
Ilocos Region	5,231	4,497	4,943	6,278	8,505	8,694
Central Luzon	22,164	22,598	23,517	23,150	23,870	24,881
Southern Tagalog	*na*	*na*	*na*	*na*	*na*	*na*
Bicol	*na*	9,648	9,933	10,133	10,325	*na*
Western Visayas	*na*	*na*	*na*	*na*	*na*	*na*
Central Visayas	9,128	9,066	16,392	18,134	16,760	*na*
Eastern Visayas	3,439	3,512	3,600	3,668	3,750	*na*
Western Mindanao	8,781	9,250	*na*	*na*	*na*	*na*
Northern Mindanao	*na*	*na*	*na*	*na*	*na*	*na*
Southern Mindanao	4,762	10,125	6,316	12,938	13,878	14,921
Central Mindanao	*na*	*na*	*na*	*na*	*na*	*na*
CARAGA	*na*	*na*	*na*	*na*	*na*	*na*
Autonomous Region for Muslim Mindanao	*na*	*na*	*na*	*na*	*na*	*na*

* Not available

The specific proposal to ensure that priority public health programs are sufficiently funded over a period long enough to meet prevalence, burden of disease, and risk factor reduction targets in NOH is to put in place multi-year performance-based budgets. Laws need to be enacted so that the budget allocation for such priority programs as TB control, vector-borne diseases control, vaccine-preventable diseases control, and reproductive health programs are set over a fixed period and are released once performance benchmarks are met. Such laws would insulate public health programs from the politics of the annual budget cycle but ensure that budget disbursements are performance-dependent.

Drafts for multi-year disease control bills have been prepared by DOH. These were presented to the National Economic and Development Authority for endorsement as priority

legislation of the new administration but were disapproved since no new funding sources were identified in the draft bills. This sad development reflects poorly on DOH managers. A fallback position should have been developed where cost requirements are realistic and where the basic funding source identified is the DOH budget itself. If it is serious about ensuring sustained disease control activities over a period of time, DOH should be willing to offer to take out from its budget the amounts required for the multi-year disease control bills.

A number of risk factors for public health program reforms under HSRA was identified from interviews conducted for this review. These may be considered obstacles to HSRA implementation in public health:

- **Budget cuts.** Especially if applied to drug procurement, budget cuts will arrest whatever progress has been gained in public health programs. Public health must be protected from cuts to reflect priority statements particularly since public health programs, unlike hospitals, have no opportunity to generate revenue.

- **No banner, no champion.** A concept or term that captures the strategic elements in public health reforms is lacking, and there is no champion pushing for public health in terms of HSRA.

- **Organizational incompatibilities within DOH.** There is no counterpart unit of NCDPC at the regional level since reengineering was put on hold. Moreover, no collaborating centers at the regional level have been established and not all hospitals have organized public health units.

3. Health Regulation

The HSRA implementation plan presents four strategic elements for health regulation reforms:

1. Conduct a review of the rationale and mandate for regulation, and then focus resources on the most critical functions;

2. Upgrade the critical regulatory capacities to a point where agencies can develop, pretest, and enforce new regulatory policies;

3. Engage third party providers including private companies to undertake testing and evaluation procedures required for licensing; and

4. Grant regulatory agencies fiscal autonomy and make access to direct subsidies conditional on regulatory performance.

Regulatory reforms focused on three DOH bureaus: BFAD, BHFS, and BHDT. BFAD and the DOH National Drug Policy (NDP) were to lead activities aimed at reducing drug

prices (i.e., through the parallel drug importation strategy), raise quality of medicines and products through the BFAD quality seal, and expand coverage of the licensing of drug retailers.

BHFS, together with PHIC, was tasked to spearhead the development of new licensing requirements for hospitals and outpatient clinics. BHDT, on the other hand, was mandated to develop and implement standards for medical equipment such as X-ray machine, infant incubator, medical laser, ventilator, and anesthesia machine.

The targets set by the HSRA implementation plan indicated that BFAD, BHFS, and BHDT quality seals and licensing requirements were to be implemented by 2002 and full compliance achieved by 2003. By 2002, these new guidelines and standard-setting mechanisms should have been in place in all convergence sites.

The BFAD seal of excellence for drug products was launched in September 2002. Those who qualify can print the BFAD quality seal on its products. But the awarding of the seal of excellence will begin only in September 2003. According to BFAD, the criteria for receiving the BFAD quality seal include bioavailability or bioequivalence, compliance to current good manufacturing practice (cGMP), track record, cost or price, and per cent of generics manufacturing in the product line.

Legally, only BFAD-licensed drug outlets should be operating in the country. However, DOH continues to receive reports of unlicensed retailers, ambulant vendors, and even drug dispensing by physicians. The HSRA implementation plan identified LGUs as a critical partner in ensuring that only licensed retailers dispense drugs and medicines. However, no arrangements or mechanisms have been developed to deputize LGUs to perform such regulatory task. It is unfortunate that BFAD ignored the opportunity to engage LGU partners where convergence site development was ongoing.

With regard to the quality assessment award system, 36 drug retailers were conferred the *Gawad Botika* award in 2001, and 64 were expected to receive the BFAD quality seal for drug retailing in 2002. Moreover, the DOH has issued through AO No. 70 s. 2002 the guidelines for accrediting or licensing *botika ng barangay* (village drugstore) or BnB. It should be noted, however, that these awards are not linked to convergence site development as provided for in the implementation plan. A plan to integrate accredited drug retail outlets into convergence site development is in the works in Southern Leyte.

The upgrading of BFAD capacities at the regional level is ongoing. The physical infrastructure for satellite laboratories in Davao and Cebu is nearly completed. Hiring of personnel to staff these facilities is in progress. However, the strategy to engage private laboratories and facilities to perform regulatory functions for BFAD remains to be acted upon. There has been no issuance of a directive to deputize or accredit private providers or laboratories. Upgrading of BFAD central facilities has been earmarked under the Social Expenditure Management Project 3 (SEMP) package of the World Bank.

Reforms expected of BHDT have hardly progressed. Only X-ray machines are being assessed in the absence of quality standards and guidelines for five other critical medical equipment: ventilator, incubator, medical laser, cautery machine, and anesthesia machine. Each of these equipment groups has a separate technical committee tasked to develop the Philippine standards for the granting of the Bureau of Product Standards (BPS) seal. BHDT convenes these bodies but claims it has no control over the pace of their work.

A team of inspectors based in the central office assesses medical X-rays and radiation-emitting devices. Pending reengineering at the Center for Health Development (CHD) level, no additional inspectors are available to conduct tests. As a result, assessment activities have prioritized only the convergence sites. However, no assessment has been done in 2002 even in the convergence sites.

Lack of funding is often raised by the regulatory agencies as an excuse for lack of progress in undertaking reforms. This is most unfortunate considering the revenue-generating potentials of most regulatory agencies. BFAD, BHDT, and BHFS need to reexamine the fees they collect for licensing and other related services. If hospitals can charge individual patients socialized fees, what is keeping regulatory agencies from charging pharmaceutical companies, hospital facilities, and drug retailers competitive rates?

According to the HSRA implementation plan, by 2002 BHFS should have implemented new licensing requirements for both hospitals and outpatient clinics. But progress, thus far, has been restricted to the development of new licensing requirements. The unified hospital accreditation and licensing system between DOH and PHIC is still being developed. The Legislative and Policy Coordinating Committee is reviewing the draft guidelines for licensing outpatient clinics before presenting it to the Secretary of Health for approval.

Assuming the paper work is dealt with, there are serious doubts as to whether the new guidelines can be effectively implemented at the field level. One obstacle is the absence of BHFS and BHDT units at the regional level that should have been provided for if reengineering had proceeded as planned.

4. National Health Insurance Program

Given the resources available to the Philippine Health Insurance Corporation, its mandate and corporate status, and its administrative infrastructure, the HSRA implementation plan did not tie up NHIP reforms exclusively to convergence site development. In addition to active participation in convergence sites, PHIC was tasked to expand enrollment, raise and expand health insurance benefits, progressively upgrade its administrative infrastructure in pace with enrollment expansion, and leverage for value for money from accredited service providers. A summary of targets and accomplishments in terms of NHIP reforms is presented in Table 8.

Membership. Progress in enrollment expansion for its Indigent Program has been impressive, especially since PHIC was able to align its implementation targets with the agenda of the new political administration. By the first half of 2002, over 900,000 families

Table 8. Target outcomes and accomplishments for NHIP reforms	
TARGET OUTCOMES	**ACCOMPLISHMENTS**
Membership	
• At least 85% of Filipinos enrolled by 2004	Met 71% of the 2002 target of 42.8 million individuals
• Minimal dropout rate among membership	No data on dropout rate in all categories
Benefits	
• Support value of at least 70%	Benefit expenditures have steadily increased despite problems computing for support value
• Outpatient services covered	Outpatient benefits covered except drugs
Quality Assurance	
• QA and cost-containment measures introduced into accreditation program	Joint *Sentrong Sigla* and PHIC accreditation for RHUS
• Alternative provider payment systems introduced	Capitation scheme for outpatient benefits
Contributions and Financing	
• 100% of contributions correctly assessed	No data available
• Remittances are complete and prompt	No data available
• Member contributions are progressive	Possible changes in contribution structure under study
Program Administration	
• Fraud control is effective	No data available. Joint PHIC and National Bureau of Investigation control measures in place
• Efficient operations of functions related to membership, contributions, and provider payment	List of accredited banks expanded. Subcontracting of these functions being considered

were enrolled in the Indigent Program of PHIC, meeting 47 per cent of its 2004 target. This enrollment figure even exceeded the so-called GMA 500 (Greater Medicare Access) target set by the President. In 2002, PHIC forged agreements with 80 per cent of provinces, 80 per cent of cities, and 75 per cent of municipalities to enroll indigent members. In addition to LGUs, PHIC managed to attract the participation of members of the Philippine Congress, the Philippine Charity Sweepstakes Organization, the Department of Agrarian Reform (DAR), the Philippine Coconut Authority (PCA), and even private corporations like GlaxoSmith-Kline to share the cost premium subsidies for the Indigent Program.

PHIC raises a number of concerns regarding the Indigent Program. The absence of long-term contractual instruments compels PHIC to negotiate for LGU premium subsidy counter-parts year in and year out. Moreover, LGUs have serious doubts whether they can raise enough resources to raise their counterpart subsidies to 50 per cent after five years of

engagement, as required by the National Health Insurance Law. In addition, low utilization rates among indigent members have led many LGUs to question the attractiveness of the program.

The Individually-Paying Program (IPP), designed to cover mainly the self-employed, was launched by PHIC in late 1999. By 2002 only a little more than 1 million members have been enrolled in IPP. Expansion in this membership category is perhaps the most challenging in terms of meeting the goal of universal health insurance coverage. PHIC is only beginning to develop alternative mechanisms to enroll, collect contributions, and manage the IPP membership based in cooperatives (e.g., DAR, PCA) and other occupation-based organizations. It is rather disappointing that LGUs have not been tapped for IPP. Enrollment and premium collection could have been integrated into LGU functions like the issuance of residence certificates and local business permits.

Benefits. While periodic increases in benefit expenditure ceilings are expected to increase the value of NHIP benefits, PHIC has been unable to present a clear estimate of the support value of benefits. This is due partly to the way its database is organized and partly to some confusion regarding how support value should be estimated. But macro level data published by the National Statistics Coordination Board suggest that benefit spending has significantly increased – the share of social health insurance to total national health expenditures increased to 6.88 per cent in 2000 from 4.83 per cent in 1999.

Benefit value is improved by introducing an outpatient benefit package covering general consultation and diagnostic services (e.g., chest X-ray, sputum microscopy, complete blood count, urinalysis, and fecalysis). This package is implemented via capitation. An expanded outpatient package that covers visual acetic acid screening for cervical cancer, regular blood pressure monitoring, annual digital rectal exam, body mass index determination, breast examination, and counseling for smoking cessation and lifestyle modification is now in place in 75 LGUs. In the pipeline are packages that cover TB DOTS and second normal spontaneous vaginal delivery or NSVD (PHIC currently reimburses only the first NSVD). The Health Passport indicating integrated package of benefits is now relabeled PhilHealth Plus.

Other measures introduced to enhance the value of benefits include expansion of hospitalization classification (beyond the current *ordinary*, *intensive*, and *catastrophic*), introduction of service capability-based hospitalization benefits matched to new classification of hospitals, and the regulation of no co-payment for indigent program members. Evidence-based (CPG) medical audit rules and drug price reference are also being integrated in the benefit scheme.

Program administration. While significant progress has been charted towards meeting its target outcomes, PHIC has yet to undertake the critical activities outlined in the implementation plan (see Table 9). As regards accreditation and licensing, there is a joint accreditation/licensing team in the regions to cover hospitals. RHUs only need *Sentrong Sigla* certification for accreditation with PHIC. An accreditation mechanism for RHUs and outpatient

clinics is now in place where the latter are utilized if the RHU in the catchment area is not *Sentrong Sigla*-certified.

Only seven CPGs have been evaluated so far and these have not been enforced as yet. As for the relative unit value (RUV), the 1995 RUV is continuously being updated. Capitation scheme is now the main provider payment mechanism for outpatient benefit packages.

Delays in investing in a full information technology (IT) system for PHIC has hindered several of its cost-containment functions including fraud control, linking of field offices at various levels and especially with accredited hospitals, membership control, and benefit expenditure monitoring. In addition to related investments in administrative infrastructure, PHIC has yet to undertake its reorganization and retooling program.

Table 9. Status of critical activities for NHIP reforms

CRITICAL ACTIVITIES	YEAR DUE	STATUS
Develop and pilot special outpatient benefit packages including TB, diagnostics, cataract, low-risk maternity, and pediatric TB	'01-'02	Partially done
Harmonize facilities licensing and accreditation	'01	Done
Develop and implement CPGs for common claims cases	'01	Not done
Implement and regularly update the 1995 RUV	'01	Done
Expand accreditation to cover RHUs and outpatient clinics	'02	Done
Maximize yield on investments	'01	Under study
Set up fraud control and prevention systems	'02-'04	No data
Establish cost-effective field office and networks nationwide	'01-'02	Done
Reengineer priority systems and retool staff accordingly	'01	Not done
Create flexible organizational structure for greater and quicker responsiveness	'01	Not done
Develop and implement drug reference pricing	'01	Not done
Review contribution structure and introduce changes to make contributions more progressive	'01	Not done
Develop and implement a social marketing program (by type of member) for PHIC enrollment	'02	Ongoing

Progress in Crosscutting Reform Activities

HSRA and its implementation plan identified five crosscutting reforms needed to manage, facilitate, set the direction of, provide incentive to, and strengthen the mandate for health sector reform. Reengineering was aimed at reorganizing and retooling the DOH bureaucracy into a unit capable of sustained reform implementation. Finance and budget reforms were intended to ensure that funds were allocated according to priorities and disbursed on the basis of performance. The tasks of managing, coordinating, and monitoring HSRA implementation at various levels and across the five reform areas were supposed to be addressed by setting up HSRA implementation units at central, regional, and local levels. Procurement reforms were designed to ensure that drugs and medicines to be procured by DOH are properly selected, of good quality, and reasonably priced. Lastly, a legislative agenda was formulated so that new laws needed to strengthen the mandate behind HSRA implementation could be promoted. Table 10 gives a summary of the status of critical activities for crosscutting reforms.

The plan to reengineer DOH was set into motion with the issuance of EO No. 102 in May 2000 by the Office of the President. DOH was to be organized around three clusters: regulation, operations, and sectoral support. Under these clusters, bureaus organized around the five HSRA reform areas were lodged. Phase 1 covered the reengineering of the DOH central office while Phase 2 covered regional offices, hospitals, and attached agencies. The regional offices or Centers for Health Development would be reorganized in the same way the central office was reconfigured.

Reengineering Phase 1 was completed save for the case of 110 members of the Malaria Eradication Workers Association of the Philippines (MEWAP) who managed to get a preliminary injunction against their deployment to new assignments. The Supreme Court has yet to decide on the case filed by MEWAP members. In 2001, Phase 2 was put on hold until "difficulties" encountered in Phase 1 were resolved. Only BFAD and PHIC are undertaking preparations to proceed with the reengineering of their respective agencies.

Retooling and retraining proceeded despite the uncertain status of Reengineering Phase 2. This effort, led by the Health Policy Development and Planning Bureau (HPDPB), was organized in three blocks: Block 1 – general gaps associated with new functions; Block 2 – specific functions concerned; and Block 3 – highly specialized functions. Blocks 1 and 2 have already been accomplished.

Table 10. Status of critical activities for crosscutting reforms		
CRITICAL ACTIVITY	**TARGET**	**STATUS**
Reengineering	• Enabling rules and regulations	Yes
	• Phase 1	Yes, except for 110 MEWAP and BFAD, BQIHS
	• Phase 2	CHDs, BFAD, and PHIC on hold
	• Retooling/Retraining	Ongoing
	• Revised office and job description	Ongoing
Budget and Finance	• Budget design consistent with HSRA implementation	Done
	• Budget allocation as designed in implementation plan	Not implemented
	• *Core*, *Mark*, *Open* budget categories in allocation	Not implemented
	• Performance-based disbursement	Not implemented
Procurement		• E- procurement system set up • Electronic tracking of distribution status of drugs • Centralized procurement of TB drugs by 2003
HSRA Implementation Unit	• Creation of HPDPB-PMO	Not done; technical coordination group yes
	• Creation of CO component PMOs	In paper only
	• Creation of HSRA site implementation teams	Yes but ad hoc

Serious HSRA implementation problems have arisen because reengineering has not been completed. The functional organization of the DOH central office has been patterned after HSRA implementation activities. However, no such organization has been set up at the regional level. This is particularly problematic for convergence site development work – regions do this on the side based on personal commitments since Local Health Assistance Division (LHAD) units continue to function on an ad hoc basis in the regions.

Baseline studies for financial management reforms have been conducted. In fact, budget officers from the central office, CHDs, and hospitals have already trained in activity-based budgeting. The DOH budget has adopted a new format reflecting the major functions needed to carry out HSRA. But the allocation of the DOH budget does not yet reflect the priorities set by the reform agenda. For example, despite cost recovery measures, hospital budgets have been steadily increasing since 2001. Performance-based budgeting is not yet in place. This is

critical especially for hospitals where cost recovery measures are in place. The budget must be used as a mechanism to help ensure that access to and quality of care for charity patients are not traded off for pay patients.

While DOH maintains that convergence site development remains its top priority, its proposed budget for 2003 says exactly the opposite. For 2002, around PhP 62 million for capital outlay for convergence sites plus PhP 40 million for *Sentrong Sigla* were allocated to support convergence site development. These amounts were cut by as much as 25 per cent in 2002 owing to DBM-imposed belt tightening. For 2003, DOH has proposed a budget with only PhP 10 million for capital outlay for convergence site development plus PhP 35 million for *Sentrong Sigla*. In effect, DOH is proposing to cut budget support for convergence sites by 56 per cent in 2003. One explanation offered was that DOH was unable to effectively defend these budget items with DBM.

The HSRA implementation plan did not identify any explicit targets for procurement reforms except for the usual greater transparency and efficiency. Prior to 2001, the scheme was for procurement to be decentralized at the regional levels using central level-determined reference prices. The reference price was determined by allowing "trusted" central office staff to bid out or negotiate for a procurement order. The price (and other conditions) determined by this sample procurement is then used as reference. This method led to at least 30 per cent reduction in the procurement price of TB drugs. DOH is now planning to revert to centralized procurement beginning 2003, possibly owing to requirements imposed by the World Bank under the SEMP loan series.

Systems have been put in place to ensure effective and graft-free procurement. DOH is currently connected to the Ourbid.com platform for electronic bidding. DOH has already installed the Contract Distribution Management Information System which is accessible online from the DOH Intranet page. Information contained includes the status of drug stocks and deliveries in up to the regional office level. It must be noted though that this facility may improve effectiveness of procurement activities but is not sufficient to reduce graft and corruption.

HSRA implementation units across levels have not been formally organized. No project management office (PMO) has been set up at the DOH central office but for a technical coordination group composed of the component managers who meet at least once a month. Each regulatory component supposedly has a technical committee but has yet to produce status or progress reports. Site implementation teams in convergence areas are in place and HSRA concerns at CHD and local levels are handled by LHAD. But since other component units (i.e., hospitals, regulation, financing, and public health) have not yet been organized, LHAD handles all HSRA concerns, imposing a heavy burden on its manpower and resources. Moreover, LHAD at the region remains as an ad hoc creation pending Reengineering Phase 2.

The bills filed in the Senate and House of Representatives in support of DOH initiatives are listed in Table 11. The status of these bills suggests that DOH seemed to have lost the

verve to advocate for the enactment of laws that would strengthen or discipline (as in the case of Senator Juan Flavier's Health Sector Reform Implementation Act) HSRA implementation.

Table 11. Status of HSRA bills in the Philippine Senate and House of Representatives

DOH PROPOSALS	STATUS OF BILLS	
	PHILIPPINE SENATE	HOUSE OF REPRESENTATIVES
1. Health Sector Reform Implementation Act of 2001	Senate Bill 3, "Health Sector Reform Implementation Act of 2001" (Sen. Flavier) • Filed on 6/30/01 • 1st Reading: 7/24/01 • Pending in the Committees on Health and Demography, Local Government, and Finance	House Bill 1579, "Providing for the Health Service Delivery Enhancement Program" (Rep. Marañon) • Pending in the Committees on Health, and Appropriations
2. Ilocos Training and Regional Medical Center Corporatization Act of 2001		HB 4909, "Creation of a Body Corporate to be Known as the La Union Medical Center" (Reps. Ortega and Dumpit) • Pending in the Committee on Government Enterprises, and Privatization
3. BFAD Regulatory Act of 2002	SB 63, "BFAD Regulatory Act of 2000" (Sen. Flavier) • Filed on 6/30/01 • 1st Reading: 7/24/01 • Pending in the Committees on Health and Demography, and Finance	HB 646, "Amending RA 3720, Strengthening and Vesting BFAD with Quasi-judicial Powers" (Rep. Escudero) • Pending with the Committee on Appropriations
4. Devices and Radiation Health Act of 2002		
5. Health Facilities and Services Act of 2002	SB 71, "Health Facilities and Services Act of 2000" (Sen. Flavier) • Filed on 6/30/01 • 1st Reading: 7/24/01 • Pending in the Committees on Health and Demography, Local Government, and Finance	HB 4664, "Amendment to the Hospital Licensure Act" (Rep. Defensor et al.) • Forwarded to the Senate on 8/5/02 for concurrence • 1st Reading: 8/7/02 • Pending with the Committees on Health and Demography, Constitutional Amendments, Revision of Codes and Laws
6. Bureau of Quarantine Act of 2002		

Section 5

Summary of the HSRA Implementation Progress

As pointed out earlier, there has been remarkable progress in convergence site development and in NHIP. But the relatively high marks in these two reform areas are pulled down by limited progress in crosscutting reforms, hospital reforms, public health, and health regulation. The slight advances in these areas restrict the integration of the five HSRA reform areas. The progress of HSRA implementation is summarized in Table 12.

Table 12. Summary of HSRA implementation progress

REFORM AREA	MAIN FINDINGS
Convergence site development	
• Number	Number of sites for convergence development may have been overestimated. Demand from LGUs seems high enough but capacity to supply required TA, training, and critical investments limited
• Site development – primary	Complete convergence not achieved; HP as an integrating instrument not pursued. PhilHealth Plus is promising but not focused on convergence sites. Full integration into an insurance package constrained by financial and actuarial risks
• Site development – expansion	First steps initiated; follow-through uncertain owing to budget cuts, unclear mandate for LHAD, and incompatibilities in the CHD organization
Crosscutting reforms	
• Reengineering	Phase 2 on hold. Political support from key reengineering consultants (now DBM and DOLE secretaries) not harnessed against MEWAP concerns
• Finance and budget	Performance-based budgeting not in place possibly because the concept is not effectively communicated in operational or practical terms
• Legislative action	Bills drafted and submitted but not given priority
• Implementation management unit	Ad hoc LHADs in regions. TCG at central office meets regularly but mandate not clear and without authority to discipline reform effort. Progress of implementation not monitored by DOH top management
• Procurement reforms	Systems still evolving; initial efforts reduced TB drug prices, but delays in procurement. Re-centralization of procurement planned next year

Table 12. SUMMARY OF HSRA IMPLEMENTATION PROGRESS (cont'd.)	
REFORM AREA	**MAIN FINDINGS**
Hospitals	
• Upgrading	Some upgrading; priorities not followed, not linked to hospital reforms nor to presence of convergence sites
• Systems	Systems that built upon HFDP technology refined and introduced
• Mandate	EO for corporatization submitted this year; status is not clear
• Cost recovery	Limited by DOF and DBM restrictions
• Quality assurance monitoring	PHIC accreditation, no CPGs introduced
• Corporatization	Awaiting EO for QMMC and ITRMC; proposal to set up an independent Philippine Hospital Authority or Commission now being revived by hospital chiefs
Local health systems development	
• Health boards activated	Limited activities off-site; no monitoring of progress of this activity at the central level
• ILHZ initiated	Limited activities off-site mainly those initiated by LHADs; BLHD seems overwhelmed
Public health programs	
• Technical leadership	Loss of skilled staff owing to turnover and reassignment
• Multi-year disease control bill	Drafted, but rejected by NEDA; DOH staff unable to defend concept
• Public health CPGs	Guidelines present, compliance not monitored
• NOH targets	No prevalence surveys since baseline
NHIP	
• Enrollment	Indigent Program enrollment under GMA 500 exceeded, but only 47% of HSRA target met. Mechanisms to enroll individual paying members not yet effective. Development in convergence sites not tapped for IPP enrollment.
• Support value (SV)	Ceilings increased, SV computation being debated
• Outpatient service package	Package launched, more in pipeline
• QA measures	No CPGs, no drug price reference
• Financing	Indigent premium subsidies not secured, contributions not progressive
• Program administration	Still no IT system; subcontracting key function; reorganization pending
OVERALL	**Implementation activities ongoing but not in all areas; poor coordination across five reform areas; budget does not reflect expressed priorities. There is an impression that nobody is on top of everything.**

A number of hypotheses has been offered to explain target shortfalls and the uneven performance of HSRA implementation and includes the following:

- Implementation strategy not effectively articulated or communicated
- Targets set too high and timetable too short

- Delays and disruption owing to political change
- Lack of leadership, no champions
- Activities poorly managed, not effectively coordinated, no monitoring
- Inadequate and inefficiently allocated budget

All of the above explanations have some validity but vary in significance from one reform area to another (see for example Table 13).

Majority of the 16 DOH regional directors (RDs) who were interviewed for this review cited budget cuts as the reason why HSRA implementation targets were not met. This is followed by the concern that the implementation strategy itself was not effectively communicated especially at the regional level and below. Half of the respondents attributed the failure to meet HSRA targets to targets that were set too high, lack of trained staff in the regions, and delays owing to change in political administration. Only 30 per cent of the respondents felt the implementation strategy was not sound and that there was no push for the reforms coming from top management.

Concepts behind the implementation strategy may not have been effectively articulated or communicated. This seems to be the case for the Health Passport and the proposal to introduce performance benchmarks in the DOH budget. HP is probably the least understood element of the implementation strategy. This lack of understanding has led to difficulties in full convergence in advanced implementation sites. In a way, between the DOH, the LGU and PHIC, Filipinos do receive a comprehensive package of health services. DOH delivers and finances tertiary care services and public health programs. LGUs, on the other hand, deliver and finance primary care and public health services. PHIC not only helps finance these services but also allows the beneficiary to access privately provided care. The idea is simply to state explicitly the entitlement that Filipinos have over these publicly delivered or financed services and assign such entitlement to a specific individual or family.

PhilHealth Plus, claimed to be the political reincarnation of HP, is moving in this direction. But designing the integration of public health and personal (outpatient and inpatient) services into an insurance package will be slow and conservative especially in the face of financial or actuarial risks. The original concept was simply to provide individual members a list of public health services provided by DOH vertical programs, primary services delivered by the LGU plus PHIC insurance benefits.

Table 13. Reasons why HSRA targets were not met, as perceived by DOH regional directors

REASONS	PER CENT OF RDs IN AGREEMENT (n=16)
Implementation strategy is not sound	30%
Implementation strategy not effectively communicated	70%
Targets too high, timetable too short	50%
No push from top management	30%
Budget requirements not available	80%
Lack of trained staff in the region, LHAD not formally organized	50%
Delay owing to change in political administration	50%

This approach needs to be reconsidered if only to ensure that national priority public health programs move in the same direction and at the same pace as the rest of the reforms.

Another area where concepts have not been effectively articulated or communicated is hospital corporatization. Resistance to hospital reform owing to group interest or ideological biases persists partly because HSRA and its implementation plan has not effectively described budget reforms as one of its integral components. Many detractors raise the concern that hospital corporatization would mean lower government subsidy for hospitals and, therefore, reduced access to care by the poor. This reading is rather unfortunate considering that in discussions on performance-based budgeting (under the crosscutting reforms section) access by the poor, especially those not yet covered by PHIC, is considered a basis for continued direct subsidy for DOH hospitals.

Targets may have been set too high for the number of sites to achieve full convergence by 2004. The demand for convergence site development is not lacking judging by the number of expansion sites and the undocumented formation of ILHZs. What the implementation plan might have underestimated was the level of difficulty and the intensity of support services required in accomplishing full convergence in a specific site. The supply bottleneck now is the capacity to provide assistance to expansion sites close to the level of effort spent for the first eight primary sites. The concern is whether DOH can sustain the level of effort given to convergence site development once it is weaned from the MSH-HSRTAP assistance.

The common explanation encountered in the review was that progress in HSRA implementation was disrupted and delayed by at least six months owing to the change in political administration in January 2001. It took a while before a new leadership for DOH and PHIC was appointed. Subsequently, the new leadership had to form its own team, take stock of the agency, and then determine whether HSRA was something to be pursued. It was only in mid-2001 when the new DOH leadership provided a clear signal (articulated by the President in her state-of-the-nation address commitments, and in AO No. 37) that convergence development was officially launched in the primary sites.

The new DOH administration also took some time to formulate its stand with regard to the more controversial components of HSRA. It was only in January 2002 when DOH reengineering was put on hold pending the resolution of Phase 1 problems. In mid-2002, DOH reset the target for hospital corporatization from five down to two facilities. Such disruptions, which might be considered necessary and unavoidable, have been too frequent in DOH – since 1986, the average tenure of a Secretary of Health is 1.7 years. The experience of countries where health sector reforms have been completed shows that sustaining reform activities required a much longer time. Mexico, for example, took nine years to undertake its reforms.

Champions to lead HSRA implementation and push for high effort levels are critical in convergence sites, regional offices, and DOH top management. At the convergence site level, local executives (i.e., governors, mayors, and local health officers) have effectively assumed leadership over HSRA implementation. At this level, the maxim "good health is good politics" seems to effectively drive the dynamics of HSRA implementation activities. In most

convergence sites, sustainability is considered secure since reversal is considered politically disastrous especially where constituents have been able to enjoy the benefits of convergence site development – improved access to services, drugs, and medicines; financial protection for indigent members; and improved access to quality care services at health centers as well as district and provincial hospitals.

At the regional level, LHAD staff continue to pursue HSRA targets. Formation of ILHZs, social marketing for indigent program enrollment, and other convergence site development activities are the main fare of LHAD. Moreover, regional staff have been flexible enough to adjust to specific conditions and political alignments in convergence sites.

What seems lacking is the technical capacity of regional staff to advise LGUs on specific reform areas like revenue retention, procurement, delivery mechanisms for national priority public health programs, and tailor-fit health insurance benefit design. However, the technical skills of local and regional champions derive considerably from external assistance (mainly from MSH-HSRTAP and Project Management Technical Advisors Team) and by *learning by doing*, an approach that tends to become less efficient as the number of expansion sites increases. Note that the project to formally develop a health leadership course for LGU health executives, DOH representatives, and DOH regional staff has not taken off. In the interim this gap was partially filled in by MHS-HSRTAP activities like the *Lakbay-Aral* (study visit) Program and the "Negotiations for HSRA Implementation" workshops.

The lack of champions for HSRA implementation is raised mainly as an issue in reform area clusters and top management in the DOH central office. At the cluster level, lack of reform champions is felt in public health, health regulations, and hospital reforms. Managers may be newly appointed and unfamiliar as yet with HSRA as may be the case with public health. Or, existing managers may have shifted to low-key effort levels in response to the lack of push, authority or clear task assignment from top management as may be the case with hospital reforms and health regulation.

Related to the question of leadership are concerns about effective management and coordination of reform activities. AO No. 37 called for the organization of implementation management and coordination units at the central, regional, and site levels. These units were expected to push for reforms, monitor progress, and recommend needed policy adjustments. But no such organization has been set up. At the central level, a technical coordination group (TCG) performs these functions but does not have the authority to discipline or set effort levels in the five reform areas. It is not even clear what TCG is accountable for and to whom it is accountable. Prior to AO No. 37, the cluster heads directly reported to the Office of the Secretary (OSEC), which orchestrated activities in the five reform areas. Now the set-up is not clear –TCG does not report to OSEC nor to a designated undersecretary (USEC) charged with overseeing HSRA implementation.

Part of HSRA management weaknesses derives from the postponement of the DOH reengineering plan. With reengineering, the DOH central office was reorganized around HSRA functional clusters. No similar organization exists at the regional level. To cope with

this shortcoming, LHAD in the regions assumes all of the work related to HSRA implementation. Hence, LHAD is overburdened, short of staff, and underfunded.

A popular explanation for target shortfalls in HSRA implementation is inadequate funding. Even if the health budget were saved from DBM cuts, resources for facility upgrading, technical assistance, training, and procurement of essential drugs and medical supplies would still be inadequate. There is very little DOH can do to augment available resources – even its ability to generate revenues from user fees, PHIC reimbursement, licensing, and other services fees is capped. But what seems really alarming is how the limited health budget is distributed among DOH functions. After taking out funds needed to operate DOH hospitals, only 30 per cent or roughly PhP 3 billion remains. Take out from this amount fixed costs (personal services and part of maintenance and other operating expenses) and less than PhP 1 billion would be left for drugs and vaccines, upgrading of regulatory agencies, support for convergence site development, development of technical or clinical practice guidelines, and introduction of hospital reforms.

CHDs spend PhP 3-4 million a year in support of convergence development in two to three sites. This amount is augmented by central (BLHD) sources set aside for this purpose amounting to an average of PhP 4 million per region. A 25 per cent budget cut uniformly applied to all budget items would mean that a CHD will have PhP 2 million less for site development support (equivalent to the resources needed to develop one convergence site). But unlike hospitals, CHD has no opportunity to generate revenues to fill in the budget deficit. The point is that budget cuts must be applied according to priorities as wells as to available revenue generation capacities.

Interviews with regional directors revealed the need for budget setting to be rationalized on the basis of performance measures (see Table 14). While 70 per cent of respondents felt that the number of indigents served by regional hospital facilities was an appropriate budget measure, only 60 per cent believed that the size of hospital was an appropriate measure. All the respondents felt that the CHD budget needs to reflect the number of convergence sites it supports. Reduction in public health threats was cited as an appropriate performance benchmark by 80 per cent of respondents.

Table 14. Bases for CHD budgets perceived as appropriate by DOH regional directors

BASES FOR SETTING CHD BUDGET	PER CENT OF RDs IN AGREEMENT (n=16)
Number of indigents served by regional hospital	70%
Number of convergence sites	100%
Reduction of public health threats	80%
Size of personnel	70%
Size of hospital	60%
Socioeconomic status of region	80%

Section 6

Recommendations for Future Implementation Activities

This review offers three sets of recommendations. The first set refers to risk factors that need to be addressed to secure the progress already accomplished. The second set points out opportunities for advancing HSRA implementation. The third set raises a number of concerns that need to be addressed as DOH updates the HSRA implementation plan.

One – address risk factors. The review identified three interrelated risk factors that must be immediately addressed to protect the gains from past efforts in convergence site development:

- **Proposed budget cut for convergence site development**
  DOH needs to rethink its position on reducing the budget allocated to leveraging for convergence site development. Of particular concern is the proposed reduction of the PhP 62 million to PhP 10 million for capital investments in convergence sites. Plans made in the expansion sites have already been prepared with the expectation that a similar support will be available in 2003.

- **High expectations generated in expansion sites**
  In addition to the list of expansion sites, several provinces and municipalities have expressed interest in undertaking convergence site development in their areas. For most of these sites, the CHD and participating LGUs have had initial discussions. The danger here is the potential backlash should DOH fail to make good its promise made during negotiations with LGUs. The resource requirements for these new sites must be carefully estimated to secure budget support.

- **Lack of capacity and clear mandate in CHD/LHAD**
  As it is, CHD/LHAD is already burdened with managing HSRA activities in convergence sites. Short of pushing through with the reengineering of regional offices, LHAD capacities must be strengthened especially where the number of ILHZs being developed is higher. Also note that total resources for site development will be much lower in 2003 given the completion of MSH-HSRTAP.

Two – exploit opportunities. A number of opportunities remains open for HSRA implementation to further advance:

- **Provide all-out support for QMMC**
  The enthusiasm for and staff support to the corporatization of QMMC remain high. This rare resource must be exploited by providing QMMC the necessary assistance to prepare it for corporatization. Apart from helping the hospital address governance issues, it must be given the capacity to develop a five-year business plan that presents annual costs (both operating and capital expenditures), makes revenue forecasts, and determines the need for continued budget support.

- **Complete convergence site development in the primary sites**
  Developments in the primary convergence sites must be pushed further. The possibilities include the use of ILHZs to deliver national priority public health programs, and tap them as agents to enroll IPP members to ultimately reach universal health insurance coverage.

- **Ensure that lessons, procedures, and solutions generated from the experience in the primary convergence sites are made known to expansion sites**
  In particular, DOH may want to consider adopting for itself the manuals and tools developed by MSH-HSRTAP to help expedite work in the expansion sites.

- **Optimize the inventory of PDI medicines**
  The impact of PDI medicines is much more felt in convergence sites than in other national distribution centers. The size of PDI purchases relative to local markets provides sufficient leverage to affect market prices. But short of allowing other importers, the inventory system at PITC must be optimized. At the very least, PITC should make sufficient advance purchase so that delays between the time local orders are made and the time when drugs are delivered are reduced to a minimum.

- **Introduce cost recovery measures for regulatory agencies**
  The relief from budget cuts enjoyed by hospitals that introduce cost recovery measures can also be applied to regulatory agencies. BFAD, BLHD, and BHDT should revise their licensing and service fees to enhance their revenue base so that they can partly finance the upgrading required.

- **Introduce PhilHealth Plus in all convergence sites**
  The cap plans (especially the TB DOTS package) must be made available in primary convergence sites.

- **Mindanao HSRA implementation**
  The basic organizational structure to manage HSRA activities in Mindanao as a single entity remains a possibility with the retention of the USEC Mindanao position. Given the attention on and the priority for development identified with Mindanao, it may be worthwhile for a Mindanao-wide health zone to

manage all five areas of HSRA implementation, generate resources from donors, and by-pass the Manila-centered government bureaucracy.

Three – update the implementation plan. There are sound technical and political reasons for DOH to formally engage in updating the HSRA implementation plan, and perhaps issue a new version of AO No. 37 s. 2002. The updating will involve a process that would review accomplishments and revise targets, determine requirements for achieving targets, organize and identify units responsible for meeting targets, and appoint a unit and grant it authority to manage and coordinate activities in all five HSRA reform areas. While updating the implementation plan, DOH might consider addressing the following issues:

- **Rationalize the DOH budget**
  An examination of how budget allocation and disbursement are consistent with the requirements of priority reform activities is called for. The possibility of introducing performance-based budgeting must also be reexamined especially in light of similar initiatives pushed by DBM.

- **Rationalize DOH hospitals' access to direct subsidies**
  A framework for revenue generation, retention, and utilization by DOH hospitals must be considered in tandem with continued access to direct government subsidies. Moreover, the determination of direct subsidies must move away from input to output or outcome-based calculation.

- **Strive for universal health insurance coverage in convergence sites**
  Requirements for meeting universal health insurance coverage at least in the primary convergence sites must be reexamined.

- **Ensure complete coverage of national priority public health programs in convergence sites**
  Vertical public health programs must begin thinking of service delivery in terms of convergence sites and ILHZs. With LGU, DOH, and PHIC support, public health programs stand a better chance of achieving complete population coverage for TB, EPI, maternal and child health and nutrition, and other priority programs. The idea behind HP might have to be reconsidered.

- **Review reengineering for regional offices**
  The mismatch between DOH central office and CHD organizational structures must be addressed by reconsidering the reengineering of regional offices. Presumably, sufficient lessons have been learned from Phase 1 so that CHD reengineering can proceed with less friction. Moreover, based on the interviews conducted, all the regional directors felt that reengineering of regional offices is necessary for effective HSRA implementation.

- **Invest in good baseline data especially for expansion sites**
  In the end, the success of convergence site development will have to be evaluated in terms of improved access to effective health care services. This assessment will not be possible if sound baseline data are not collected.

Annex A

Summary HSRA Implementation Progress in the Eight Primary Convergence Sites

*Annex Table 1. Progress in convergence site development in Pangasinan**

TARGETS	PROGRESS
Health Financing	
• At least 85% with insurance (social health insurance [SHI]) • Social marketing • Political support and funding	• 8,869 indigent members (representing 20% of the population) enrolled • Social marketing initiated by PHIC and local executives • Premiums shared by province and municipality (7 of 48 LGUs or 14.5% with Indigent Program) • 18 municipalities have signed a MOA with PHIC
Integrated Package and Benefits	• 5 of 48 RHUs (10.4%) are PHIC-accredited
Hospital Reforms	
• Financial management system • Income generation, retention, and utilization • Quality assurance • Facility upgrading • Networking with private sector	• 44 of 51 hospitals (86.2%) are PHIC-accredited (includes 12 of 15 government hospitals) • Training on financial management undertaken • More efficient billing and collection system with patient social services classification • Cost analysis of each hospital cost center • Prescribed drugs sold at pharmacy • Hospital revenues increased from PhP 2.4 million in 1999 to PhP 10 million in 2000 • Revenues are used to upgrade facilities, purchase drugs, share funds with 14 other hospitals, and for personnel incentives • QA committee and quality improvement teams established in each hospital • TC established in the hospital • Provincial hospital upgraded as tertiary hospital; PHIC-accredited • Networking with Villaflor hospital and non-government organizations (NGOs)
Medicines and Equipment	
• Therapeutics committee • Retention of income from sales • Bulk procurement program • Parallel drug importation program	• TC actively meeting and functioning • Income from drugs sales retained and held in trust • Bulk procurement in 14 government hospitals even before MSH-HSRTAP (1998) • PhP 240,000 worth of PDI drug ordered, delivered, and distributed to all district hospitals
Local Health Systems	
• Inter-local health zones with MOA signed • Inter-LGU cost sharing	• ILHZ not yet organized • MOA for ILHZ drafted but not yet signed • Apart from premium subsidy sharing no other form of inter-LGU cost sharing exists

* Officially started March 2001

*Annex Table 2. Progress in convergence site development in Capiz**	
TARGETS	**PROGRESS**
Health Financing	
• At least 85% with insurance (SHI) • Social marketing • Political support and funding	• 9,511 enrolled beneficiaries • Social marketing campaign initiated by PHIC/DSWD • Enrollees shared by province and municipalities (8,699 indigents enrolled by the province; 812 enrolled by municipalities)
Integrated Package and Benefits	• 11 RHUs are PHIC-accredited
Hospital Reforms	
• Financial management system • Income generation, retention, and utilization • Quality assurance • Facility upgrading • Networking with private sector	• Adoption of systematic hospital billing and collection after MSH-HSRTAP assistance • Increased income from PHIC Indigent Program • 90% of hospital income retained for hospital operations • User fees collected are fixed, not graduated • QA programs introduced with HSRTAP support • Availability of medicines in the pharmacy has improved • Upgrading of hospital equipment (e.g., X-ray machine) and laboratory services • Networking with Metro Manila hospitals (e.g., Makati Medical Center, St. Luke's Medical Center)
Medicines and Equipment	
• Therapeutics committee • Retention of income from sales • Bulk procurement program • Parallel drug importation program	• TC actively meeting and functioning • Profits from dugs sales retained by hospitals • Bulk bidding; pooled procurement for hospitals • Parallel importation introduced but has caused considerable delay in delivery especially in the last few shipments. While questions about sustainability are being raised, Capiz has ordered an additional PhP 252,000 worth of PDI
Local Health Systems	
• Inter-local health zones with MOA signed • Inter-LGU cost sharing	• 5 ILHZs with signed MOA • Manpower sharing between ILHZs

* Officially started March 2001

*Annex Table 3. Progress in convergence site development in Bulacan**

TARGETS	PROGRESS
Health Financing	
• At least 85% with insurance (SHI) • Social marketing • Political support and funding	• 11,809 indigents enrolled (14.7%) • Social marketing campaign initiated by PHIC/DSWD • 6,665 enrollees shared by the province; 2,952 by municipalities; 2,193 by a congressman
Integrated Package and Benefits	• RHUs awaiting PHIC accreditation
Hospital Reforms	
• Financial management system • Income generation, retention, and utilization • Quality assurance • Facility upgrading • Networking with private sector	• Training on financial management conducted • Private room/ward charges competitive with that in private sector • All hospital income remitted to provincial government • Proposal from hospital chiefs to allocate income for use of each hospital • Quality standards developed for hospital • Client feedback mechanism established ("*Isumbong mo kay* Gov. Josie" [Report it to Gov. Josie] section) • Tertiary provincial hospital evolving into Bulacan Medical Center • Private health care providers service mostly the urban population
Medicines and Equipment	
• Therapeutics committee • Retention of income from sales • Bulk procurement program • Parallel drug importation program	• TC meets quarterly; is functioning • 80% of income utilized as revolving fund for hospital drugs procurement; 20% remitted to provincial funds • Bulk procurement posted savings of over PhP 3 million • Request for PDI arrived only recently; delays are causing some disappointment with PDI program
Local Health Systems	
• Inter-local health zones with MOA signed • Inter-LGU cost sharing	• 2 united local health districts • MOA signed • No cost sharing apart from premium subsidy contributions

* Officially started June 2001

Annex Table 4. Progress in convergence site development in South Cotabato *

TARGETS	PROGRESS

Health Financing	
• At least 85% with insurance (SHI) • Social marketing • Political support and funding	• 10,032 indigents enrolled (19.66%) • Social marketing campaign initiated by PHIC/DOH/Provincial Health Office/LGU • Premiums shared by province, municipalities, and *barangays* (all 11 municipalities with indigency funds)
Integrated Package and Benefits	• 10 RHUs are PHIC-accredited but only 4 RHUs receive capitation for outpatient benefits
Hospital Reforms	
• Financial management system • Income generation, retention, and utilization • Quality assurance • Facility upgrading • Networking with private sector	• More efficient billing and recording system with computerization • Additional pay rooms/wards to be constructed in provincial hospital • Revenue enhancement schemes not yet operating • QA workshops conducted for hospital chiefs and administrator • Hiring of private medical consultants for provincial hospital on honorarium basis • Networking with private health care providers
Medicines and Equipment	
• Therapeutics committee • Retention of income from sales • Bulk procurement program • Parallel drug importation program	• Hospital TC reactivated • Revolving drug fund for hospitals managed by provincial treasurer's office as trust account • Bulk procurement for hospitals ongoing • PhP 845,000 worth of PDI ordered in October 2001 and delivered in June 2002
Local Health Systems	
• Inter-local health zones with MOA signed • Inter-LGU cost sharing	• 5 local area development zones • No cost-sharing schemes other than premium subsidy contributions • Functional referral system

* Officially started June 2001

Annex Table 5. Progress in convergence site development in Negros Oriental*

TARGETS	PROGRESS
Health Financing	

• At least 85% with insurance (SHI) • Social marketing • Political support and funding	• 6,063 beneficiaries enrolled • Social marketing program initiated by PHIC/DSWD • Most municipalities shoulder cost, 2 municipalities share cost with the province, 1 municipality shares with beneficiaries (10 of 22 LGUs with indigency program)
Integrated Package and Benefits	• 3 RHUs are PHIC-accredited
Hospital Reforms • Financial management system • Income generation, retention, and utilization • Quality assurance • Facility upgrading • Networking with private sector	• Hospital boards recommend utilization of hospital income • Income generated and retained from hospital fees and charges, and utilized • Income managed by provincial treasurer's office as trust fund • 5 Ss (Sort, Systematize, Sweep, Standardize, Self-discipline) implementation • Quality improvement surveys conducted • Public service excellence program in place • Upgrading of hospital equipment and facilities ongoing
Medicines and Equipment • Therapeutics committee • Retention of income from sales • Bulk procurement program • Parallel drug importation program	• TC reactivated • Part of total requirements obtained through bulk procurement; remaining amount is bid separately causing delays • PhP 554,000 worth of PDI has been ordered; partial delivery recently made
Local Health Systems • Inter-local health zones with MOA signed • Inter-LGU cost sharing	• 6 ILHZs with 5 core referral hospitals with MOA • 3 ILHZs with common funds and cost-sharing schemes • Referral system strengthened

* Officially started April 2001

Annex Table 6. Progress in convergence site development in Misamis Occidental*

TARGETS	PROGRESS

Health Financing	
• At least 85% with insurance (SHI) • Social marketing • Political support and funding	• 9,000 indigents enrolled (19.1%) • Social marketing initiated by PHIC/DSWD; tri-media campaign used • Province and municipalities shoulder cost (7 of 17 municipalities with indigency program)
Integrated Package and Benefits	• 7 of 17 RHUs are PHIC-accredited
Hospital Reforms	
• Financial management system • Income generation, retention, and utilization • Quality assurance • Facility upgrading • Networking with private sector	• Finance and management systems yet to be operational • Income from hospital fees and charges, private rooms • Reimbursement from PHIC • Income goes to provincial treasury but a proposal for income utilization has been developed • 5 Ss and 6 Cs (Comprehensive health care, Competent/Well-managed hospital, Caring/Compassionate/Communicating staff, Culture-friendly, Community-oriented, Clean and green) quality assurance program in place • Feedback mechanism for patients and beneficiaries in place • Hospital upgraded using *Sentrong Sigla* award of PhP 2.4 million • No formal networking is operational
Medicines and Equipment	
• Therapeutics committee • Retention of income from sales • Bulk procurement program • Parallel drug importation program	• TC reactivated with good leadership • Revenue retention from drugs sales in trust fund managed by *Botika* (drugstore) Provincial Task Force • Pooled procurement program operational • Province has only recently participated in PDI and ordered PhP 262,000 worth of medicines
Local Health Systems	
• Inter-local health zones with MOA signed • Inter-LGU cost sharing	• 2 ILHZs with MOA signed • No actual contributions yet, but ILHZs LGUs agreed to share cost • Referral system strengthened

* Officially started October 2001

Annex Table 7. Progress in convergence site development in Pasay City*

TARGETS	PROGRESS
Health Financing	

• At least 85% with insurance (SHI) • Social marketing • Political support and funding	• 9,050 of indigents enrolled within the city (60.3%) • Social marketing initiated by PHIC/DSWD/city • Premiums shouldered by the city government
Integrated Package and Benefits	• All RHUs are PHIC-accredited
Hospital Reforms • Financial management system • Income generation, retention, and utilization • Quality assurance • Facility upgrading • Networking with private sector	• Pasay City General Hospital is PHIC-accredited • Training on financial management conducted for hospital administration • Income from hospital fees and charges • Improvements in billing and collecting procedures made • Reimbursement from PHIC increasing • Income goes to the city government • Proposal for fiscal autonomy is being developed
Medicines and Equipment • Therapeutics committee • Retention of income from sales • Bulk procurement program • Parallel drug importation program	• TC to be revitalized
Local Health Systems • Inter-local health zones with MOA signed • Inter-LGU cost sharing	• City is divided into two zones with one health center per zone • Functioning referral system

* Officially started October 2001

*Annex Table 8. Progress in convergence site development in Nueva Vizcaya**	
TARGETS	**PROGRESS**
Health Financing	
• At least 85% with insurance (SHI) • Social marketing • Political support and funding	• 10,913 of indigents enrolled (60.6%) • PHIC initiated social marketing particularly of the indigent program • Enrollees shared by province and municipalities (100% of municipalities with indigent program)
Integrated Package and Benefits	• 4 of 15 RHUs are PHIC-accredited
Hospital Reforms	
• Financial management system • Income generation, retention, and utilization • Quality assurance • Facility upgrading • Networking with private sector	• 4 of 5 hospitals (1 private, 4 government) are PHIC-accredited • Financial management systems have yet to be in place • Provincial hospital revenues increased from PhP 4.2 million in 1999 to PhP 4.6 million in 2000 and PhP 5.5 million in 2001 • Provincial government retains revenue and determines its utilization • Upgrading of facilities, cleaning of surroundings • 5 Ss application; all 4 government hospitals are *Sentrong Sigla*-accredited • No upgrading of hospital classification
Medicines and Equipment	
• Therapeutics committee • Retention of income from sales • Bulk procurement program • Parallel drug importation program	• Hospital TC functioning • Facilities do not retain revenue from drugs sales • Pooled drug procurement program in place • Special procurement team has been organized • Province recently ordered PhP 203,000 worth of PDI
Local Health Systems	
• Inter-local health zones with MOA signed • Inter-LGU cost sharing	• Province-wide ILHZ (expanded Provincial Health Board) • No formal MOA signed for ILHZ • No inter-LGU cost sharing apart from premium subsidies for indigent enrollees • Referral system strengthened

* Officially started July 2001